2017-2018 Employee Benefits Guide

A personal guide to your health

2017-2018 Benefits

AREF 4 EXECUTIVE PARK EAST NE SUITE 355 ATLANTA GA30329

BENEFIT HIGHLIGHTS

AREF's goal is to maintain quality and options while managing overall healthcare costs. We take pride in our benefit offerings, which are among the most generous in the industry!

- **Enrollment Period:** The enrollment period runs through your 31st day of employment.
- **Plan Year:** The plan year will begin on April 1, 2017 and end on March 31, 2018.
- ***When can I change my benefits?*** When you experience a qualified life event or during the annual enrollment period, each March.
- ***What is a qualified life event?*** A qualified life event (QLE) is when you or a dependent (i.e., spouse or child) experience a change that allows you to make a change to your elections. These include change in marital status, birth or adoption, death, employment status, and possibly more.

Please review your plan options and costs during the enrollment period.

Your Carriers

Medical:
Kaiser Permanente

Dental:
United Concordia

Vision:
Superior

Life:
Standard

Voluntary Life:
Standard

403(b):
Nationwide

Three Easy Steps

- **Review the materials...**

  Everyone receives a package containing detailed information on the plans, mandated notices and information about your rights in New Hire Orientation and at Open Enrollment. For this reason, it's important to keep this packet in an easily accessible spot if you need to refer back to it in the future.

- **Make a decision...**

  Carefully review the plan materials and ask questions so that you may make an informed decision to best fit your personal needs.

- **Go online...**

  Visit https://workforcenow.adp.com > Myself > Benefits > Enrollments to make your health plan elections — even if you plan to waive any or all of the benefits.

  Be sure check out the *Need Help With Your Enrollments?* section on the right side of the page.

  When you have completed the election process, view and print your Benefits Statement.

For More Information

ADP Workforce Now: https://workforcenow.adp.com

Your Benefits Guide: This is your hard-copy resource for plan information. Extra copies may be requested through AREF Human Resources.

Want help with deductions and take-home pay? *Check out the Paycheck Calculators via https://workforcenow.adp.com > Myself > Pay > Calculators. You will be directed to PaycheckCity, a site designed to help you estimate your take-home pay and calculate other options.*

Questions?
Contact Ellen Schneider, HR Manager at ellen.schneider@va.gov or 770-415-9193 (direct).

Medical Coverage - Kaiser HMO	
Type of Plan	**HMO**
Deductible	
Individual	Not Applicable
Family	Not Applicable
Out of Pocket Maximum	
Individual	$6,350
Family	$12,700
Lifetime Maximum	Unlimited *(Some benefits may have limitations)*
Coinsurance	Not Applicable
Physician's Office Visits	
Primary Care	$25 Copay
Specialty Care	$50 Copay
Preventive	Plan pays 100%
Maternity *(Obstetrician / Midwife)*	Plan pays 100%
Inpatient Facility Charge	$500 Copay
Outpatient Facility Charge	$100 Copay
After- Hours Urgent Care	$45 Copay, per visit
Emergency Room	$200 Copay, per visit *(waived if admitted)*
Prescription Drugs - *Mail Order Available. Contact Kaiser Permanente Customer Service for more detail.*	
Kaiser Permanente Pharmacies	
Generic Drugs	$15 Copay
Brand Preferred Drugs	$30 Copay
Network Pharmacies - Walgreens and Rite Aid	
Generic Drugs	$25 Copay
Brand Preferred Drugs	$40 Copay
Eligibility Date	Date of Hire
Contact Information	www.kp.org 404-261-2590 888-865-5813 toll free

Medical Coverage - Kaiser Multi Choice			
Type of Plan	**Select Providers (Tier 1)**	**PPO Providers (PHCS) (Tier 2)**	**Non- Participating Providers (Tier 3)**
Deductible			
Individual	$200	$1,200	$2,400
Family	$600	$3,600	$7,200
Out of Pocket Maximum			
Individual	$1,200	$3,200	$6,400
Family	$3,600	$9,600	$19,200
Lifetime Maximum	Unlimited *(Some benefits may have limitations)*	Unlimited *(Some benefits may have limitations)*	Unlimited *(Some benefits may have limitations)*
Coinsurance	Plan Pays 90% after Annual Deductible	Plan Pays 80%, after Annual Deductible	Plan Pays 60%, after Annual Deductible
Physician's Office Visits			
Primary Care	$30 Copay	$40 Copay	Plan Pays 60% after Deductible
Specialty Care	$40 Copay	$50 Copay	Plan Pays 60% after Deductible
Preventive	Plan pays 100%	$40 or $50 Copay	Plan Pays 60% after Annual Deductible
Maternity *(Obstetrician / Midwife)*	Plan pays 100%	Plan Pays 80% after Annual Deductible	Plan Pays 60% after Annual Deductible
Inpatient Facility Charge	Plan Pays 90% after Annual Deductible	Plan Pays 80% after Annual Deductible	Plan Pays 60% after Annual Deductible
Outpatient Facility Charge	Plan Pays 90% after Annual Deductible	Plan Pays 80% after Annual Deductible	Plan Pays 60% after Annual Deductible
After- Hours Urgent Care	$50 Copay, per visit	$60 Copay, per visit	Plan Pays 60% after Annual Deductible
Emergency Room	$200 Copay, per visit *(waived if admitted)*	$200 Copay, per visit *(waived if admitted)*	$200 Copay, per visit *(waived if admitted)*
Prescription Drugs - *Mail Order Available. Contact Kaiser Permanente Customer Service for more detail. Network pharmacies include Walgreens and Rite Aid.*			
Generic Drugs	$15 Copay	$20 Copay	$20 Copay
Brand Preferred Drugs	$30 Copay	$50 Copay	$50 Copay
Non-Preferred Drugs	$45 Copay	$75 Copay	$75 Copay
Eligibility Date	Date of Hire		
Contact Information	www.kp.org 404-261-2590 888-865-5813 toll free		

Dental Coverage - United Concordia		
Type of Plan	**Passive PPO**	
	In-Network	**Out-of-Network** *Subject to Usual and Customary*
Deductible		
Individual	$50 *(waived for Preventive)*	
Family	$150 *(waived for Preventive)*	
Plan Year Maximum	$1,000 Per Covered Member	
Annual Maximum Rollover	If you receive at least one cleaning per year and use a total benefit of less than $500, you will be rewarded with a $300 increase in the next year's benefit maximum, to a maximum of an additional $1,200.	
Preventive (Type I) *See Frequency Schedule*	100% Routine Exams, X-rays, Cleanings, Fluoride	100% Routine Exams, X-rays, Cleanings, Fluoride
Basic (Type II)	80% Fillings, Root Canal, Simple Extractions	80% Fillings, Root Canal, Simple Extractions
Major (Type III)	50% Onlays, Crowns, Dentures, Complex Extractions, Anesthesia	50% Onlays, Crowns, Dentures, Complex Extractions, Anesthesia
Orthodontia	Not Covered	Not Covered
Smile for Health - Wellness	100% Periodontal Coverage for those with qualifying medical conditions.	
Eligibility Date	First of the month following date of hire	
Contact Information	www.unitedconcordia.com 1-800-332-0366	

Vision Coverage - Superior Vision		
	Includes: Wal-Mart, Sam's Club, VisionWorks, Target Optical, LensCrafters, ForEyes, America's Best, JC Penney, Sears	
	In-Network	**Out-of-Network** *Reimbursement for Services* *Copays for Services are* *Deducted from Reimbursement*
	Every 12 Months	
Eye Exam	$10 Copay	Ophthalmologist: Up to $42 Optometrist: Up to $37
Prescription Lenses	**Every 12 Months**	
Single	Covered in Full	Up to $32
Bifocal	Covered in Full	Up to $46
Trifocal	Covered in Full	Up to $61
Progressive	Covered at Lined Trifocal Level	Up to $61
Frames	**Every 24 Months**	
	$100 Retail Allowance	Up to $48
Materials (Lenses and/or Frames)	$25 Copay	
Contact Lens Benefit	**Every 12 Months - in lieu of glasses**	
Contact Lens Fitting Fee	Standard: Covered in Full Specialty: $50 Allowance	Not Covered
Medically Necessary	Covered in Full	Up to $210
Conventional	$150 Retail Allowance	Up to $100
Eligibility Date	First of the month following date of hire	
Contact Information	www.superiorvision.com 1-800-507-3800	

Life and AD&D - The Standard

Basic Coverage			
Employee Basic Life	$25,000		
Employee Basic AD&D	$25,000		
Monthly Contribution	Employer Paid		
Eligibility Date	First of the month following date of hire		
Voluntary Life Coverage			
Employee	Increments of $10,000 up to $100,000 without Evidence of Insurability (Guarantee Issue available at initial eligibility), up to the lesser of $500,000 or 5 times annual earnings.		
Spouse	Increments of $5,000 up to $25,000 without Evidence of Insurability (Guaranteed Issue available at initial eligibility), up to $100,000 not to exceed 100% of employee's election.		
Employee and Spouse Monthly Contributions based on employee age and coverage amounts elected	**Age**	**Employee Cost Per $10,000**	**Spouse Cost Per $5,000**
	<29	$0.920	$0.460
	30-34	$1.170	$0.585
	35-39	$1.450	$0.725
	40-44	$1.700	$0.850
	45-49	$2.440	$1.220
	50-54	$3.920	$1.960
	55-59	$6.800	$3.400
	60-64	$9.470	$4.735
	65-69	$15.090	$7.545
	70+	$28.360	$14.180
Eligible Child(ren)	Election of: $2,000, $4,000, $5,000 or $10,000 6 months - 20 years of age (24 if full-time student)		Monthly contribution: $0.200 per $2,000
Voluntary Accidental Death and Dismemberment	Same benefit election as Employee and Spouse Voluntary Life Insurance		Monthly contribution: $0.025 per $1,000
Eligibility Date	First of the month following date of hire		
Contact Information	www.standard.com 1-800-628-8600		
Health Advocate			
Healthcare Help	A medical, benefits or claims expert can help you with complex conditions, find specialists, address eldercare issues, clarify insurance coverage, work on claims denials, help negotiate medical bills and more.		
Contact Information	www.healthadvocate.com 1-866-695-8622		
Employee Advocate			
Contact Information	If you need assistance with your Medical, Dental, Vision and/or Life benefits, or have questions regarding an Explanation of Benefits, a bill you received, or any benefit coverage issues and concerns, please call your Employee Advocate, Traci Blake, at **1-888-517-3659**, or email **tblake@cbiz.com** for personalized service.		

2017 Bi-Weekly Deductions

Dental Coverage - United Concordia

	20 Hours/Week	22 Hours/Week	24 Hours/Week	26 Hours/Week	28 Hours/Week	30 - 40 Hours/Week
Employee (EE) Only	$7.42	$6.68	$5.94	$5.20	$4.45	$0.00
EE + Spouse Only	$21.91	$21.17	$20.42	$19.68	$18.94	$14.49
EE + Children Only	$19.64	$18.90	$18.16	$17.42	$16.67	$12.22
EE + Family	$37.70	$36.96	$36.22	$35.48	$34.73	$30.28

Vision Coverage - Superior Vision

	20 Hours/Week	22 Hours/Week	24 Hours/Week	26 Hours/Week	28 Hours/Week	30 - 40 Hours/Week
Employee (EE) Only	$1.33	$1.20	$1.07	$0.93	$0.80	$0.00
EE + Spouse Only	$3.94	$3.80	$3.67	$3.54	$3.40	$2.60
EE + Children Only	$3.84	$3.71	$3.57	$3.44	$3.31	$2.51
EE + Family	$6.53	$6.40	$6.26	$6.13	$6.00	$5.20

Medical Coverage - Kaiser HMO

	20 Hours/Week	22 Hours/Week	24 Hours/Week	26 Hours/Week	28 Hours/Week	30 - 40 Hours/Week
Employee (EE) Only	$109.03	$98.12	$87.22	$76.32	$65.42	$0.00
EE + Spouse Only	$370.64	$359.74	$348.84	$337.93	$327.03	$261.61
EE + Children Only	$338.02	$327.12	$316.22	$305.32	$294.41	$229.00
EE + Family	$599.60	$588.69	$577.79	$566.89	$555.99	$490.57

Medical Coverage - Kaiser Multi-Choice POS

	20 Hours/Week	22 Hours/Week	24 Hours/Week	26 Hours/Week	28 Hours/Week	30 - 40 Hours/Week
Employee (EE) Only	$144.94	$134.04	$123.14	$112.24	$101.33	$35.92
EE + Spouse Only	$449.66	$438.75	$427.85	$416.95	$406.05	$340.63
EE + Children Only	$411.66	$400.76	$389.86	$378.95	$368.05	$302.64
EE + Family	$716.33	$705.43	$694.52	$683.62	$672.72	$607.30

This plan intends to offer coverage that meets the minimum essential coverage and affordability portions of the Shared Responsibility portion of the Patient Protection and Affordable Care Act.

Atlanta Research and Education Foundation - Employee Advocate

If you need assistance with your Medical, Dental, Vision and Life benefits or have questions regarding an Explanation of Benefits, a bill you received or any benefit or coverage issues and concerns, please call your Employee Advocate at 1-888-517-3659 or email Traci Blake - tblake@cbiz.com for personalized service.

Direct Inquiries

If you have questions about your Medical (HMO or Multi Choice) benefits, call:
Kaiser Permanente
1-888-865-5813
www.kp.org

If you have questions about your Dental benefits, call:
United Concordia
1-800-332-0366
www.unitedconcordia.com

If you have questions about your Vision benefits, call:
Superior Vision
1-800-507-3800
www.superiorvision.com

If you have questions about your Basic Life, AD&D and/or Voluntary Life call:
The Standard
1-800-628-8600
www.standard.com

If you need additional assistance with complex claims issues, eldercare, claims denial, finding a specialist call:
Health Advocate
1-866-695-8622
www.healthadvocate.com

2017 Health Plan Notices

* Women's Health and Cancer Rights Act of 1998

"Did you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy – related services, including reconstruction and surgery to achieve symmetry between the breasts, prosthesis, and complications resulting from a mastectomy (including lymphedema"). Please call your plan administrator for more information.

* The Genetic Information Nondiscrimination Act (GINA)

The Genetic Information Nondiscrimination Act of 2008, also referred to as GINA, is a new federal law that protects Americans from being treated unfairly because of differences in their DNA that may affect their health. The new law prevents discrimination from health insurers and employers. The President signed the act into federal law on May 21, 2008. The parts of the law relating to health insurers will take effect by May 2009, and those relating to employers will take effect by November 2009.

Who needs protection from genetic discrimination?

Everyone should care about the potential for genetic discrimination. Every person has dozens of DNA differences that could increase or decrease his or her chance of getting a disease such as diabetes, heart disease, cancer or Alzheimer's. It's important to remember that these DNA differences don't always mean someone will develop a disease, just that the risk to get the disease may be greater.

More and more tests are being developed to find DNA differences that affect our health. These tests (called genetic tests) will become a routine part of health care in the future. Health care providers will use information about each person's DNA to develop more individualized ways of detecting, treating and preventing disease. But unless this DNA information is protected, it could be used to discriminate against people.

Why was the law needed?

The law was needed to help ease concerns about discrimination that might keep some people from getting genetic tests that could benefit their health. The law also enables people to take part in research studies without fear that their DNA information might be used against them in health insurance or the workplace.

* Newborns' and Mothers' Health Protection Act of 1996 (Newborn's Act)

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

General Notice of COBRA Continuation Coverage Rights
** Continuation Coverage Rights Under COBRA**

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Ellen Schneider, 4 Executive Park East NE, Suite 355, Atlanta, GA 30329.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information: Ellen Schneider, 4 Executive Park East NE, Suite 355, Atlanta, GA 30329; 770-415-9193.

Important Notice from Atlanta Research and Education Foundation About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Atlanta Research and Education Foundation and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

2. **Atlanta Research and Education Foundation has determined that the prescription drug coverage offered by Kaiser Permanente, is on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Atlanta Research and Education Foundation coverage may be affected.

If you do decide to join a Medicare drug plan and drop your current Atlanta Research and Education Foundation coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Atlanta Research and Education Foundation and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Atlanta Research and Education Foundation changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov

- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	April 1, 2017
Name of Entity/Sender:	Atlanta Research and Education Foundation
Contact--Position/Office:	Ellen Schneider
Address:	4 Executive Park East NE, Suite 355 Atlanta, GA 30329
Phone Number:	770-415-9193

GEORGIA CONSUMER CHOICE OPTION

What is Consumer Choice?
Georgia law requires insurers to offer a "Consumer Choice" option to members enrolling in an insured HMO, POS or PPO plan. This Consumer Choice option allows members to receive services from a non-network provider (physician, hospital or other provider) while still being covered at an in-network level.
Although members may "nominate" any non-network provider, the nominated doctor or hospital must first agree to the following in order for the member's services to be covered at the in-network rate:

1) Accept the insurer's reimbursement as payment in full (in addition to the member's usual copayments, deductibles and/or coinsurance)
2) Comply with the insurer's utilization management programs

Is there a charge to elect the Consumer Choice Option?
Yes. The law allows insurers to increase the monthly premium rate for members who elect this offering. The amount of the monthly premium increase is 17.5% for Consumer Choice Option HMO and POS benefit plans, and 10% for Consumer Choice Option PPO plans.

How do I choose the Consumer Choice Option?
Selecting the Consumer Choice Option is just like selecting any other benefit option. You must do so either at open enrollment, if you are a new hire, or when your employer's eligibility rules allow you to do so. To select the Consumer Choice Option:

1) *Newly applying members* must complete the insurer's Member Enrollment Application and select the Consumer Choice Option plan desired. (Members must still select a network Primary Care Physician for each person enrolled if a HMO or POS Consumer Choice Option is selected.)
2) *Currently enrolled members* must complete a Member Change Form and select the Consumer Choice Option plan desired.

How is the Consumer Choice Option different from a PPO or POS plan?
A PPO or POS plan allows members access to out-of-network providers at an out-of-network benefit level. When a member utilizes the services of an out-of-network provider, the member usually pays more in the form of increased copayments, deductibles and/or coinsurance.
Under the Consumer Choice Option, members may utilize the services of an out-of-network provider at in-network benefit levels only when that provider has:

1) Been nominated by the member:
2) Signed a form accepting the insurer's conditions; and
3) Been approved by the insurer.

After a provider has been approved, the member's benefits are paid as though the provider were part of the insurer's network.

Once I elect the Consumer Choice Option, can I go to any doctor and get benefits paid at in-network levels?

No. First, you must complete a Provider Nomination Form and receive notification from the insurer that the nomination has been accepted before out-of-network providers can be reimbursed at in-network benefit levels. For any nomination to be approved the provider must sign the nomination form agreeing to the insurer's terms and conditions before that provider's services will be covered at in-network levels. The provider has absolute discretion regarding whether he or she wishes to participate in the Consumer Choice Option.

How do I nominate my physician?
Call the insurer's customer service department to request a Consumer Choice Physician Nomination Form. Members must complete the provider nomination form, which is a two-step process:

1) The provider must sign the nomination form and request details about the insurer's reimbursement rates for the services he or she intends to provide.
2) The provider must sign the form <u>again</u> to indicate his or her acceptance of the rates and other terms and conditions, once he or she has reviewed them.

After you have completed these steps, please return the completed nomination form to the insurer for approval.

How long will it take to get approval of a nominated provider?
Once the insurer has received a completed nomination form – completed and signed by both the provider and the member – they will respond by mail or fax within three business days.
What if I select the Consumer Choice Option and then decide I want to return to a non-Consumer Choice Option plan?

Under most employers' rules, you may make a plan election only once during each year. If your employer's rules allow you to switch plans other than during your open enrollment period, you may move from the Consumer Choice Option plan you elected back to the non-Consumer Choice version of that plan within 31 days of enrolling. Please check with your employer for details. Your employer must submit any such requests in writing to the insurer.

What if my doctor doesn't want to accept reimbursement terms or comply with utilization management guidelines required by the insurer?

The law does not obligate a provider to accept the terms and conditions or reimbursement rates. If a provider elects not to sign the Consumer Choice Option Provider Nomination Form, he or she is under no obligation to do so.

If you are seeking services from a specific provider, check with that provider BEFORE completing the Consumer Choice Option application and making a final plan election. Once you have selected a Consumer Choice Option plan, you cannot switch plans until the following open enrollment, except within 31-day grace period described above.
Once a doctor has agreed to your terms, can I receive services from that doctor or hospital for the remainder of the time I'm enrolled in the health plan?

Once the provider has signed the form agreeing to the reimbursement and other terms and conditions, you may utilize the services of the provider until your plan's anniversary the following year. You will need to repeat the nomination/approval process each year for the out-of-network provider's services to be covered at in-network benefit levels.

Will prescriptions written by a non-network doctor be covered?
If you nominate a provider and that provider is ultimately approved under the Consumer Choice Option, he or she may write prescriptions that will be covered at in-network benefit levels. Remember, if your plan restricts you to having prescriptions filled at network pharmacies, you must either use only network pharmacies or have a completed and approved Provider Nomination Form for any non-network pharmacy. (Note: This requirement does not apply to PPO plans.)

If my doctor admits me to a non-network hospital, will the hospital charges be covered?

Any services must be provided by either a network hospital or a hospital for which a Provider Nomination Form has been completed and approved. This form must also be completed and approved for any other providers rendering services – for example, radiology, anesthesia services, physical therapy or lab work. To be eligible for in-network benefit levels, all services must be provided by either in-network providers or providers approved under the Consumer Choice Option.

Medicaid and the Children's Health Insurance Program (CHIP)

Offer Free Or Low-Cost Health Coverage To Children And Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**.

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of July 31, 2015. You should contact your State for further information on eligibility –

GEORGIA – Medicaid
Website: http://dch.georgia.gov/ Click on Programs, then Medicaid Phone: 1-800-869-1150

To see if any more States have added a premium assistance program since July 31, 2015, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

Atlanta Research and Education Foundation

4 Executive Park East NE, Suite 355
Atlanta, GA 30329
Ellen Schneider, HR Manager
770-415-9193 * ellen.schneider@va.gov

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get a copy of your health and claims records	• You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct health and claims records	• You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. • We are not required to agree to your request, and we may say "no" if it would affect your care.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive	• We can use your health information and share it with professionals who are treating you.	***Example:*** *A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*
Run our organization	• We can use and disclose your information to run our organization and contact you when necessary. • **We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.** This does not apply to long term care plans.	***Example:*** *We use health information about you to develop better services for you.*
Pay for your health services	• We can use and disclose your health information as we pay for your health services.	***Example:*** *We share information about you with your dental plan to coordinate payment for your dental work.*
Administer your plan	• We may disclose your health information to your health plan sponsor for plan administration.	***Example:*** *Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests and work with a medical examiner or funeral director	• We can share health information about you with organ procurement organizations. • We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

This Notice of Privacy Practices applies to the following organizations.

Ellen Schneider, HR Manager * 770-415-9193 * ellen.schneider@va.gov

Your AREF Summary of Benefits and Coverage (SBC) Can Be Found Online

Availability of Summary Health Information

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

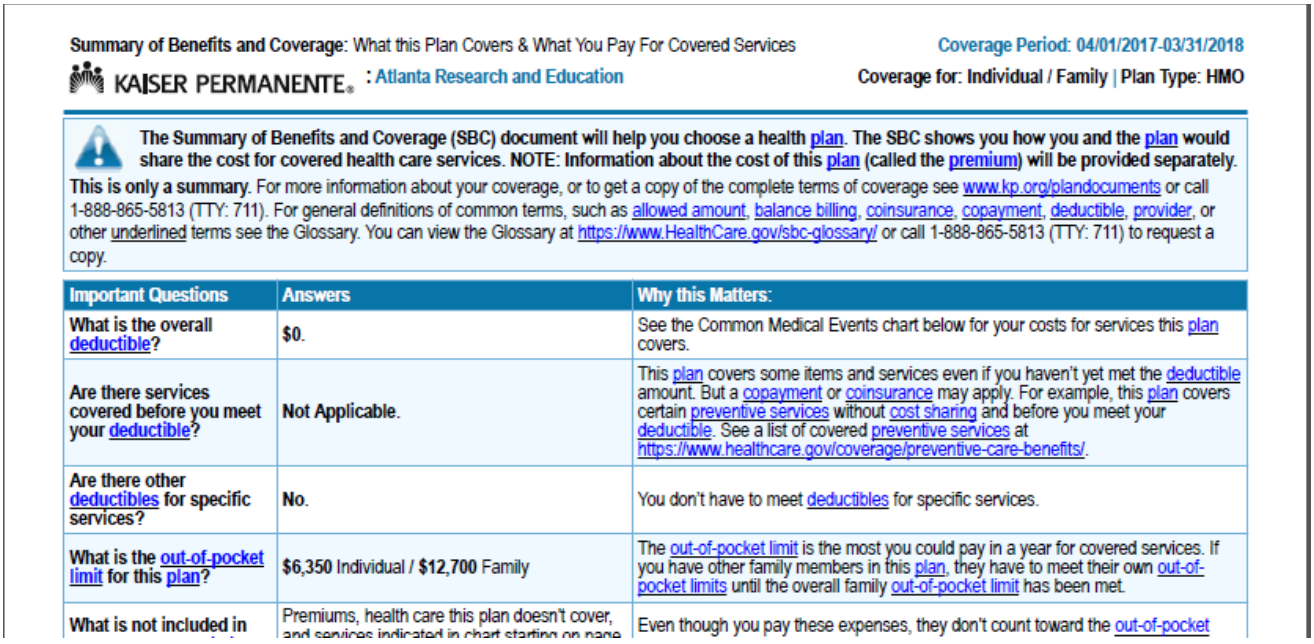
Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options.

The SBC for both the Kaiser HMO and Multi Choice plan, as well as a Glossary of Health Coverage and Medical Terms can be found on ADP Workforce Now.

1. Go to https://workforcenow.adp.com
2. From the Home page, navigate to the *Company News and Announcements* section in the middle of the page.
3. Click on the links under *Important Insurance Information*.

If you would like to request a hard copy of the Summary of Benefits and Coverage and Glossary of Health Coverage and Medical Terms, please submit your request in writing to:

Ellen M. Schneider, PHR, Human Resources Manager
Atlanta Research and Education Foundation, Inc. (AREF)
4 Executive Park East NE, Atlanta, GA 30329; or email to ellen.schneider@va.gov



Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services — Coverage Period: 04/01/2017-03/31/2018

KAISER PERMANENTE® : Atlanta Research and Education — Coverage for: Individual / Family | Plan Type: HMO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage see www.kp.org/plandocuments or call 1-888-865-5813 (TTY: 711). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.HealthCare.gov/sbc-glossary/ or call 1-888-865-5813 (TTY: 711) to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$0.	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not Applicable.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$6,350 Individual / $12,700 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in	Premiums, health care this plan doesn't cover, and services indicated in chart starting on page	Even though you pay these expenses, they don't count toward the out-of-pocket

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 2-28-2017)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Ellen Schneider * 4 Executive Park East NE, Suite 355, Atlanta GA 30329 * 770-415-9193 * ellen.schneider@va.gov.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name	4. Employer Identification Number (EIN)
Atlanta Research and Education Foundation	58-1857346
5. Employer address	**6. Employer phone number**
4 Executive Park East NE, Suite 355	770-415-9193

7. City	8. State	9. ZIP code
Atlanta	GA	30329

10. Who can we contact about employee health coverage at this job?	
Ellen Schneider	
11. Phone number (if different from above)	**12. Email address**
	ellen.schneider@va.gov

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☑ Some employees. Eligible employees are:

    Employees working 20 or more hours per week.
- With respect to dependents:
  - ☑ We do offer coverage. Eligible dependents are:

    Legal spouses, domestic partners and dependent children up to age 26.
  - ☐ We do not offer coverage.

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☑ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☑ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

* An employer–sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Notes

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Disclaimer: This Benefit Guide provides a brief summary of the benefits available under the Atlanta Research & Education Foundation's Benefit Program. In the event of any discrepancy(ies) between this summary and any Document, Insurance Contract or Certificate, the Insurance Document(s) will prevail. All benefits provided by the Foundation are subject to change and are further subject to such greater requirement as may apply as a matter of state and federal law. While AREF intends to continue group benefit plans indefinitely, it reserves the right to amend or discontinue all or some of them at any time, subject to applicable laws and regulations. If a plan is terminated and not replaced with comparable benefits, participants in the plan(s) will be notified. The plan documents control in the event of any conflict between the statements in the handbook and the plan. *Please remember that actual benefits provided, as well as eligibility requirements, are determined by the plan documents.* For information, refer to the plan document or contact AREF Human Resources.